All-Payer Claims Database Submission
Frequently Asked Questions (FAQ)
July 2011

Revision History

Date	Version	Description	Author
3/2/11	2.0	Incorporate all FAQs into one document and reformat for categories and dates addressed	M. Prettenhofer
4/1/11	2.0	A1 and A5 updated with 2/28/2011 Test and Production File Due Date.	M. Prettenhofer
4/1/11	2.0	A6 updated with May 2011 Filing Date	M. Prettenhofer
4/1/11	2.1	A7 update to clarify versioning use	M. Prettenhofer
4/1/11	2.0	A9 and A11 updated to refer to A66 for revised filing requirements	M. Prettenhofer
4/1/11	2.0	A23 updated to reflect v2.1 Variance Request process of January 2011 through May 2011	M. Prettenhofer
7/5/11	2.2	Q&As 74 and 75 added to clarify use of dates in headers for all file types	M. Prettenhofer

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Claims

Claims – Behavioral

Q37	**What files must a standalone Behavioral Health carrier submit?**	10/15/2010
A37	For standalone Behavioral Health carriers who offer either direct benefits to group accounts or individuals, or benefits via a contract with a medical carrier, it is expected that the carrier will submit behavioral health claims using the Medical File format, along with a Member Eligibility, Provider and Product File. Stand alone carriers are able to submit variance requests for data elements that they feel are not applicable to their business model. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request should indicate that the data elements requested are not applicable to a Behavioral Health Carrier. No variance request is necessary for the Dental and Pharmacy Files. Your Organization Submitter ID (OrgID) will indicate which files a carrier is required to submit.	10/15/2010

Claims – Dental

Q31	**Do dental carriers need to submit one Dental Claims file or multiple Dental Claims files?**	10/15/2010
A31	Dental carriers should submit one Dental Claims File for all of their members that are not linked to a direct contract with one of the medical carriers. This would include claims related to all group or individual policies a dental carrier would have in Massachusetts.	10/15/2010
Q32	**If a Dental Carrier has direct contracts with one or multiple payers how should this data be submitted?**	10/15/2010
A32	This data can be submitted along with all other claims data for group or individual accounts. In this instance the Dental Carrier should provide the Group of Policy Number in DC006 (Insured Group of Policy Number) of DC042 (Product ID Number) that can be used to link the member to a specific medical carrier.	10/15/2010
Q33	**What other files and fields must a Dental Carrier submit other than claims?**	10/15/2010
A33	Dental Carriers must submit a Member Eligibility, Provider and Product file. The Division understands that many of the fields in these files are more likely associated with medical carriers. In these instances, Dental carriers should submit this information in the variance request. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request should indicate that the data elements requested are not applicable to a Dental Carrier. No variance request is necessary for the Medical and Pharmacy Files. Your Organization Submitter ID (OrgID) will indicate which files a carrier is required to submit.	10/15/2010

Claims – Medical

Q21	**What is the difference between fields MC099 (Non-Covered Amount) and MC114 (Excluded Expenses). Is this the dollar amount charged that is above the plans limitations?**	10/15/2010
A21	APCD defines Non-covered Amount as: Items and/or services that are not covered by the carrier as part of the contract/eligibility/benefit and denied upon supplier or provider claim submission APCD defines Excluded Expenses as: Items and/or services that are typically covered by the carrier as part of the member's contract/eligibility/benefit but at the claim level have been over-utilized or delivered by a non-approved, non-credentialed supplier or provider.	10/15/2010
Q56	**Please provide clarification regarding billing, service and plan rendering provider information. Fields MC024-MC035 captures data related to the servicing provider. If carrier only stores information related to billing provider may this be stored in these fields?**	12/15/2010
A56	No. If the billing provider is strictly a billing entity, and is not a provider of services, we would not want that information repeated in the service provider fields. See clarification of Servicing and Plan Rendering fields below. **Fields MC024-MC035 - Servicing provider data:** The set of fields MC024-MC035 are all related to the servicing provider **entity**. The Division wishes to collect entity level rendering provider information here, and at the lowest level achievable by the carrier. If the carrier only knows the billing entity, and the billing entity is not a ***service rendering*** provider, then the billing provider data (MC076-MC078) is ***not*** appropriate. In this case the carrier would need a variance request for the service provider fields. If the carrier only has the data for a main ***service rendering*** site but not the specific satellite information where services are rendered, then the main service site ***is*** acceptable for the service provider fields. For example – XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and ultimately the goal. A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134. **Fields MC134 Plan Rendering Provider and MC135 Provider Location:**	12/15/2010

The intent of these fields is to capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely who and where the service was rendered. If the carrier does not know who actually performed the service or the specific site where the service was actually performed, the carrier will need a variance request for one or both of these fields. It is not appropriate to load facility or billing information here.

Q57	**For Field MC117 Authorization Required, is the state asking for services that had authorizations or for services that required authorizations, whether the authorization was requested and approved or not?**	12/15/2010
A57	For claims which required a pre-authorization the value in this field should be '1' for Yes.	12/15/2010

Claims – Pharmacy

Q38	**What files must a standalone Pharmacy carrier submit?**	10/15/2010
A38	For standalone Pharmacy Carriers who offer either direct benefits to Medicare Part D recipients, group accounts or individuals, or benefits via a contract with a medical carrier, it is expected that the Pharmacy Carrier should submit claims using the Pharmacy file format, along with a Member Eligibility and Product file. Stand alone pharmacy carriers are able to submit variance requests for data elements that they feel are not applicable to their business model. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request should indicate that the data elements requested are not applicable to a Standalone Pharmacy Carrier. No variance request is necessary for the Medical, Dental and Provider files. Your Organization Submitter ID (OrgID) will indicate which files a carrier is required to submit.	10/15/2010
Q39	**Are Pharmacy Benefit Managers (PBMs) required to submit claims?**	10/15/2010
A39	While most medical carriers are submitting the pharmacy claims sent from contracted PBMs each month, PBMs are also required to resend those same claims to the Division. If the medical carriers do not receive pharmacy claims for self-insured medical accounts, PBMs are required to send the pharmacy claims to the Division.	10/15/2010

Claims – Vision

Q34	**Does a medical carrier need to submit vision claims?**	10/15/2010

A34	Vision claims that are covered under a health plan's medical product should be submitted along with the Medical Claims File in the medical claims format. On the Eligibility File, the Vision Benefit Indicator (ME118) would be equal to '1' for Yes. If the Vision Provider is contracted directly with the medical carrier, we would expect a record in the Provider file as well for the providers. The Division recognizes that some fields in the Medical File are not applicable for vision claims, but expects vision claims to be an extremely small percentage of claims. Detail on standalone vision carriers' submissions is provided in another question.	10/15/2010
Q35	**What files must a standalone vision carrier submit?**	10/15/2010
A35	For standalone vision carriers who offer either direct benefits to group accounts or individuals, or benefits via a contract with a medical carrier, it is expected that the vision carrier will submit vision claims using the Medical File format, along with a Member Eligibility, Provider and Product File. Stand alone carriers are able to submit variance requests for data elements that are not applicable to their business model. The variance should state a Proposed Threshold of 0% with all the other proper columns filled out. The Rationale in Column I of the variance request should indicate that the data elements requested are not applicable to a Vision Carrier. No variance request is necessary for the Dental and Pharmacy files. The Organization Submitter ID (OrgID) will indicate which files a carrier is required to submit.	10/15/2010
Q36	**If a Vision Carrier has direct contracts with multiple payers how should this data be submitted?**	10/15/2010
A36	This data can be submitted along with all other claims data for group or individual accounts. In this instance the Vision Carrier should provide the Group of Policy Number in MC006 (Insured Group of Policy Number) of MC079 (Product ID Number) that can be used to link the member to a specific medical carrier.	10/15/2010

Claims – Voids

Q12	**How should carriers submit reversed or voided claims?**	10/15/2010
A12	The Division explains this process in detail at the following link: (See Reference File - Claim Voids and Replacements – Versioning Protocol.doc)	10/15/2010

Communications

Q60	**Where can I find the most recent Administrative Bulletin 11-05 posted January 26, 2011?**	2/22/2011
A60	*Click to download PDF file –* http://www.mass.gov/Eeohhs2/docs/dhcfp/g/ab/1105.pdf *Click to download Word document –* http://www.mass.gov/Eeohhs2/docs/dhcfp/g/ab/1105.doc	2/22/2011

Eligibility File - General

Q10	**What does one record equal in the Member Eligibility File?**	10/15/2010
A10	The file should contain one record per member per product per eligibility time period. If medical and pharmacy benefits are delivered via two separate products rather than a bundled product (e.g.: HMO Medical 1000 and RX Bronze) we expect two records, one for HMO Medical 1000 and one for RX Bronze. The Prescription Drug Coverage indicator (ME019) would have a value of '2' for No in the HMO Medical 1000 eligibility record, and the Medical Coverage indicator (ME020) would have a value of '1' for Yes. Those two field values would be reversed in the RX Bronze eligibility record. Each product would also need to be in the Product File, with PR006 indicating that the product is a Pharmacy, Medical or other product. We would expect the product Benefit Type to correlate to the flags in the Eligibility File. For example for the Product File record for the HMO Medical 1000 we would expect PR006 product Benefit Type to be '1' which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of '2' for 'Pharmacy Only' in PR006.	10/15/2010
Q11	**Are carriers required to submit retroactive eligibility changes each month?**	10/15/2010
A11	Yes. See the summary filing requirements grid in the attached link. Refer to Question / Answer 66 for revised APCD Summary Filing Requirements	04/01/2011
Q41	**How often should a carrier submit the Last Activity Date (ME056) field in the eligibility file?**	12/15/2010
A41	Last Activity Date was a field of interest by GIC, and therefore only required of GIC carriers. Submit the last activity date relevant to an eligibility change using your best judgment.	12/15/2010
Q43	**Please provide clarification on the meaning of Disease Management Flag (ME053) on the eligibility file?**	12/15/2010
A43	This field is used to identify whether a member with a chronic condition (Diabetes, Asthma, Depression, COPD, and CHF) is participating in a health management program, care coordination, or health coaching and wellness program that the health plan sponsors either internally or through the use of an external vendor. For example, the member has asthma and participates in an asthma management program, or the member was identified as having high clinical risks due to multiple chronic conditions and participates in a health coaching program to ensure proper health education and access to preventive care and exams.	12/15/2010
Q45	**If a member enrolled in the product prior to 1/1/2008, should the carrier report that original enrollment date in field ME041 (product enrollment date) or should the carrier= report 20080101?**	12/15/2010
A45	Carriers should report the original date of the member's enrollment in the product, even if it is prior to 2008.	12/15/2010

Q46 **Field ME050 (Member Deductible Used) is asking for "the amount to date the member has paid into deductible". Should that amount reported include the deductible paid over the entire span of time reported in fields ME041 and ME042 (Product Enrollment Start and Product Enrollment End) or only the most recently plan year within the product enrollment start and product enrollment end dates?** 12/15/2010

A46 This field should represent the current value of the Annual deductible incurred pertinent to the timeframe which it represents. Examples are presented below. 12/15/2010

On the legacy files for 2008-2010

For the file ending 12/31/09 ME050 represents the EOY 2009 deductible incurred by the member for 2009 [EOY: End of Year]; For the file ending 12/31/10 ME050 represents the EOY 2010 deductible paid for 2010

Going forward beginning January 2011:

File ending 01/31/11 ME050 represents the end Jan 2011 deductible incurred by the member for 2011. This field will be cumulative over the course of the year if the member incurs more deductible charges.

Q47 **Does the Division want carriers to report (ME050) Member Deductible Used on a paid or incurred basis?** 12/15/2010

A47 The Division does not expect the payer to contact the provider to see if the member paid their deductible to the provider. The value in this field represents the patient's deductible responsibility for claims that have been paid by the carrier. 12/15/2010

Q48 **What is the formula carriers should use to report Member Deductible (ME049)?** 12/15/2010

A48 Carriers shall submit the maximum amount the member would pay out of pocket towards in-network deductibles for the annual time period. Out of pocket costs for co-pay or coinsurance are excluded from this calculation. This deductible amount applies to all possible benefit deductibles. If the maximum individual deductible is $2000 for the year, $2000 would be reported in the field. 12/15/2010

Q49 **If Product Enrollment Start Date (ME041) and Product Enrollment End Date (ME042) spans multiple plan years, should carriers populate ME049 (Member Deductible) with the plan year deductible times the number of plan years spanned by ME041 and ME042 or just a single plan years deductible?** 12/15/2010

A49 Carriers should submit the deductible for the latest plan year to date. 12/15/2010

Q50 **What amounts should be reported in the Deductible fields, (ME111-ME116). Is it based on incurred or paid data?** 12/15/2010

A50 The eligibility deductible fields specific to each benefit are not based on actual patient deductibles incurred or paid. These fields indicate the maximum amount that the member's product, group and/or contract require for certain types of services. For example if a member had a maximum annual deductible of $2000 per 12/15/2010

year across all services, but there is up to $1500 medical deductible, and up to a $750 deductible for pharmacy and $300 for dental, and $200 for behavioral health, the Division needs to see the maximum amount related to each deductible type, and understands that the maximum out of pocket deductible will not exceed $2000 based on the value in ME049 (Member Deductible).

Eligibility File – Race / Ethnicity / Language

Q44	**The Eligibility Submission Guide states to use NULL for Ethnicity 1 and Ethnicity 2 (ME025 & ME026) when it's not collected; however, there is no similar statement on the Member Language Preference (ME033). If a carrier does not collect ME033 and reports NULL for ME033, does the carrier need to include this as part of a variance request?**	12/15/2010
A44	The Eligibility Submission Guide Version 2.1 has been updated to address this issue. The filing requirements for member language preference are consistent with the race and ethnicity data elements.	12/15/2010
Q55	**Does race and ethnicity need to be self reported by the member? Can a carrier use derived race and ethnicity values using surname analysis and/or geo-coding software?**	12/15/2010
A55	Race and ethnicity data should be self-reported by the member. A carrier should not submit data derived by surname analysis, geo-coding software, and/or any other methodology without the Division's prior approval.	12/15/2010

General

Q7	**Should monthly submissions contain full replacement files or adds/changes and deletes?**	10/15/2010
A7	Monthly submissions are typically originals. However if a claim line is being altered in any way from a previous month, it would appear as a change. Refer to Claim Voids and Replacements – Versioning Protocol.doc	04/01/2011
Q8	**For fields where there will be some percentage of records with no value does the Division prefer a blank or a NULL?**	10/15/2010
A8	NULL should be reported.	10/15/2010
Q9	**What is the frequency of the submissions for each file type, both historically starting in January 2011, and ongoing starting in February 2011?**	10/15/2010
A9	Refer to Question/Answer 66 for revised APCD Summary Filing Requirements.	04/01/2011
Q13	**What types of claims should carriers submit for January 2008, the first month of data submissions?**	10/15/2010
A13	Carriers may submit all claims paid in January 2008, but the Division will filter out claims with service dates in 2007.	10/15/2010

General – Header / Trailer Dates

Q74	**What do I put for the start and end dates for the claims files (for single and multiple months)?**	07/05/2011
A74	All Claims Files are *single* month reporting only, multiple months in one file is not an allowed submission. When submitting data for Claims Files for any given month, the Period Beginning Date (HD005) should have the **year** and **month** reported in CCYYMM format. The Period Ending Date (HD006) must have the same exact **year** and **month** reported in CCYYMM format as the Period Beginning Date. There are validation elements in the Trailer that must match the two Header elements; TR005 must match the date reported in HD005 and TR006 must match the date reporting in HD006. It is important that the submitter selects that same exact reporting period when preparing the submission in SENDS+. Submissions where the SENDS+ Date and the Header/Trailer Dates differ will be dropped by the system.	07/05/2011
Q75	**What files have multiple months reported within them and how do I code the start and end dates for them?**	07/05/2011
A75	Files that have multiple months reported within them are the Member Eligibility Files (ME), Provider Files (PV) and the Quarterly Product Files (PR).	07/05/2011

Member Eligibility (ME)
The historical ME Files incorporated two years of data in one file to decrease the submission burden on submitters. One for eligibilities from 2008 through 2009 and

another for 2009 through 2010. For the 2008 through 2009 submission the HD005, HD006, TR005 and TR006 should all have 200912 reported in them. In SENDS+ you must select the Year = 2009 and the Month = 12. For the 2009 through 2010 submission the HD005, HD006, TR005 and TR006 should all have 201012 reported in them. In SENDS+ you must select the Year = 2010 and the Month = 12.

Although the current ME Files are monthly starting in January 2011, it is still based upon a rolling 24 months. For these files the Header and Trailer dates (along with the SENDS+ dates) are always equal to the month reported for. Example: the file submitted in February 2011 for January 2011 will have Header and Trailer Dates equal to 201101 and in SENDS+ you must select the Year = 2011 and the Month = 1. The eligibilities reported within this file are from February 2009 through January 2011.

Provider File (PV)

The historical PV File is actually rolled into a current month submission, 201105 and should contain all contracted providers from January 2008 through May 2011. The HD005, HD006, TR005 and TR006 should all have 201105 in them. In SENDS+ you must select the Year = 2011 and the Month = 05.

The current PV Files are monthly and start January of 2011. The current submissions are to contain all active providers for the month reported.

Product File (PR)

The historical PR File incorporates three years and one quarter's worth of Products that were active at anytime during the 39 months. The HD005, HD006, TR005 and TR006 should all have 201105 in them. In SENDS+ you must select the Year = 2011 and the Month = 5.

The current PR Files are quarterly, (contains three months of Product information in one file) starting in January 2011, based on a Calendar Year quarter: the Four Quarter Ends are March (Quarter1), June (Quarter 2), September (Quarter 3) and December (Quarter 4).

The first file due in January 2011 is for the December (Quarter 4) Submission. The HD005, HD006, TR005 and TR006 should all have 201012 in them. In SENDS+ you must select the Year = 2010 and the Month = 12. Each quarter reporting after that must have the quarter period ending date in the Header/Trailer elements and the corresponding time periods selected in SENDS+.

The Quarter Endings for 2011 are: 201012 due in January, 201103 due in April, 201106 due in July and 201109 due in October.

General – Negative Values

Q42	**Can a carrier submit negative dollar amounts in any of the dollar fields on the claims and eligibility files?**	12/15/2010
A42	Carriers can submit negative amounts in the dollar fields of the claims files. However, the Division does not expect negative amounts in the dollar fields of the eligibility file.	12/15/2010

Go-Live Submissions

Q5 **When am I required to send production data?** 10/15/2010

A5 All carriers must submit production data by February 28, 2011. See A61 for submission file requirements in March 2011 and each month thereafter. Carrier may submit production files after test files pass the APCD format rules, thresholds and data validation edits. 04/01/2011

Q61 **What are payers required to submit between February 2011 – May 2011?** 2/22/2011

A61 The Division has provided an APCD Filing Requirements Summary – Feb 2011 document that outlines the reporting expectations for the six file types for the February 2011 – May 2011 reporting period. 2/22/2011

(See Reference File - APCD Filing Requirements Summary – Feb 2011.xls)

Q62 **What are payers required to submit by February 28th?** 2/22/2011

A62 2/22/2011

APCD Filing
Medical Claims (MC)
Required Reporting
1 file - Paid claims for November 2010
1 file - Paid claims for December 2010
1 file - Paid claims for January 2011
Pharmacy Claims (PC)
Required Reporting
1 file - Paid claims for November 2010
1 file - Paid claims for December 2010
1 file - Paid claims for January 2011
Dental Claims (DC)
Required Reporting
1 file - Paid claims for November 2010
1 file - Paid claims for December 2010
1 file - Paid claims for January 2011
Member Eligibility (ME)
Required Reporting
1 file - Member Eligibility for November 2010 **(Member Eligibility file includes December 2008 – November 2010)**
1 file - Member Eligibility for December 2010 **(Member Eligibility file includes January 2009 – December 2010)**
1 file - Member Eligibility for January 2011 **(Member Eligibility file includes February 2009 – January 2011)**
**Each file must have members eligible and having one day of Massachusetts residence for their respective month or any time in the prior 23 months respectively.*
Product File (PR)

Required Reporting
1 file – Product file (Quarterly Submission) - (January 2011 Product (PR) file includes October 2010 – December 2010) **Each file includes all products referenced in the prior quarter. Note that some products in this file may reference new products for the current or future time periods.*
Provider File (PV)
Required Reporting
1 file – Includes all providers referenced in the Claims files for November 2010, December 2010, and January 2011 as well as any currently contracted Massachusetts providers regardless of claims.

(See Reference File - APCD Filing Requirements Summary – Feb 2011.xls)

Q63 **What are payers required to submit by March 31st?** 2/22/2011

A63 2/22/2011

APCD Filing
Medical Claims (MC)
Required Reporting
1 file – Paid claims for February 2011
Pharmacy Claims (PC)
Required Reporting
1 file – Paid claims for February 2011
Dental Claims (DC)
Required Reporting
1 file – Paid claims for February 2011
Member Eligibility (ME)
Required Reporting
1 file – Member Eligibility for February 2011 (Member Eligibility file includes March 2009 – February 2011) **Each file must have members eligible and having one day of Massachusetts residence for their respective month or any time in the prior 23 months respectively.*
Product File (PR)
Required Reporting
No Product file submitted (next quarterly submission by 04/30/2011)
Provider File (PV)
Required Reporting
1 file – Includes all providers referenced in the Claims files for February 2011 as well as any currently **contracted Massachusetts providers regardless of claims.**

(See Reference File - APCD Filing Requirements Summary – Feb 2011.xls)

Q64 **What are payers required to submit by April 30th?** 2/22/2011

A64 2/22/2011

APCD Filing
Medical Claims (MC)
Required Reporting
1 file – Paid claims for March 2011
Pharmacy Claims (PC)
Required Reporting
1 file – Paid claims for March 2011
Dental Claims (DC)
Required Reporting
1 file – Paid claims for March 2011
Member Eligibility (ME)
Required Reporting
1 file – Member Eligibility for March 2011 **(Member Eligibility file includes April 2009 – March 2011)** **Each file must have members eligible and having one day of Massachusetts residence for their respective month or any time in the prior 23 months respectively.*
Product File (PR)
Required Reporting
1 file – Product file (Quarterly Submission) (April 2011 Product (PR) file includes January 2011 - March 2011) **Each file includes all products referenced in the prior quarter. Note that some products in this file may reference new products for the current or future time periods.*
Provider File (PV)
Required Reporting
1 file – Includes all providers referenced in the Claims files for March 2011 as well as any currently contracted Massachusetts providers regardless of claims.

(See Reference File - APCD Filing Requirements Summary – Feb 2011.xls)

Q65 **What are payers required to submit by May 31st?** 2/22/2011

A65 By May 31, 2011, payers are required to submit the monthly reporting requirement as well as the data from 2008, 2009, and 2010. 2/22/2011

***Legacy data reporting requirement (2008, 2009, and 2010)**

APCD Filing
Medical Claims (MC)
Required Reporting

36 files - Monthly collections of claims paid for each month between January 1, 2008 and December 31, 2010
Pharmacy Claims (PC)
Required Reporting
36 files - Monthly collections of claims paid for each month between January 1, 2008 and December 31, 2010
Dental Claims (DC)
Required Reporting
36 files - Monthly collections of claims paid for each month between January 1, 2008 and December 31, 2010
Member Eligibility (ME)
Required Reporting
1 file – Member Eligibility file includes January 1, 2008 to December 31, 2009 **1 file –** Member Eligibility file includes January 1, 2009 to December 31, 2010 **Member Eligibility file includes all persons eligible for any part of the timeframe between January 1, 2008 and December 31, 2010.*
Product File (PR)
Required Reporting
1 file – Complete file includes all products referenced in the Member Eligibility files retroactive back to January 1, 2008
Provider File (PV)
Required Reporting
1 file – Complete file includes all providers referenced in the Claims files retroactive to January 1, 2008 as well as any contracted Massachusetts providers regardless of claims.

***May 2011 Reporting Requirement**

APCD Filing
Medical Claims (MC)
Required Reporting
1 file - Paid claims for April 2011
Pharmacy Claims (PC)
Required Reporting
1 file - Paid claims for April 2011
Dental Claims (DC)
Required Reporting
1 file - Paid claims for April 2011
Member Eligibility (ME)
Required Reporting
1 file - Member Eligibility for April 2011 **(Member Eligibility file includes May 2009 – April 2011)**

*Each file must have members eligible and having one day of Massachusetts residence for their respective month or any time in the prior 23 months respectively.
Product File (PR)
Required Reporting **No Product file submitted** (next quarterly submission by 07/31/2011)
Provider File (PV)
Required Reporting **1 file –** Includes all providers referenced in the Claims files for April 2011 as well as any currently contracted Massachusetts providers regardless of claims.

(See Reference File - APCD Filing Requirements Summary – Feb 2011.xls)

Historical Submission Production

Q66	**Can payers submit all required historical and current data before February 28th? Or before May 31st?**	2/22/2011
A66	To avoid unnecessary payer burden, the Division recommends the submission of only the required files as outlined in the APCD Filing Requirements Summary – Feb 2011.xls. Payer submissions will not be processed for file level pass or failure until the thresholds are approved in the certified variance application. Therefore, any historical data submitted will not be processed until a certified variance request is granted. After a variance request is approved and certified, the Division may process historical file submissions but payers will be responsible for resubmitting files that do not meet the terms of the variance agreement.	2/22/2011
Q67	**The APCD Filing Requirements Summary specifies the May 31st data submission to include data from 2008, 2009, and 2010, including the November 2010 and December 2010. Are payers required to resubmit November 2010 and December 2010 by May 31st?**	2/22/2011
A67	By May 31, 2011, payers are required to have submitted all historical data from 2008, 2009, 2010 and submissions for January 2011 through May 2011. As payers examine edit reports based on the production data submitted in February, March, and April 2011 and engage in active discussions with the Division through the variance request review process, payers may find it necessary to make corrections and submit any prior month's submissions. The Division will allow for resubmission of files until a payer's final variance request has been certified. While payers are not required to resubmit the November 2010 and December 2010 data before May 31st, payers must ensure those previously submitted files will pass certified thresholds and other reporting requirements.	2/22/2011

Lookup Tables

Q4	**When do I submit Carrier Specific Lookup Tables?**	10/15/2010
A4	The submission guides identified a number of fields that the carrier may submit lookup tables for. If applicable, these tables should be submitted along with each carriers test files in the appropriate format. The Division has sent out the approved format for these tables to each of the carriers.	10/15/2010
Q58	**Is there a method for carriers to update lookup tables should carrier lookup values and descriptions change?**	12/15/2010
A58	Carriers should submit reference data by completing the standard DHCFP template which should be used for the initial submission and subsequent updates. The template and instructions for submitting the data are available on the Division's website – (Link: Carrier Defined Lookup Table Worksheet)	12/15/2010

Production Time

Q6	**Can carriers submit historical data earlier than January 31, 2011?**	10/15/2010
A6	Carriers may submit historical data anytime during May 2011, as long as it is able to pass the data formats, approved thresholds and data validation rules.	04/01/2011

Product File

Q52	**Is the intent of the (PR001) Product ID to identify a unique combination of values across all the fields in the file? Alternatively, could DHCFP accept multiple rows with different Product IDs and Product names (PR002) but the same values in all other fields (i.e., exact duplicate rows except for product ID and name) or would these get rejected?**	12/15/2010
A52	DHCFP will accept multiple rows with different Product IDs and Product Name (PR002) but the same values in all other fields. This would indicate to DHCFP that the product is either branded differently to certain accounts, although it has the same base characteristics, or that some of the specifics of the product may differ from one Product ID to another, e.g.: no deductible for lab tests in one product while the other product has a $200 lab deductible.	12/15/2010
Q53	**Is DHCFP's main interest for the Product File to understand benefits related to deductibles and drug coverage? Is that the only real differentiation between Products required other than fully/self insured?**	12/15/2010
A53	No. There are multiple reasons for the Division collecting product information including linking patient costs and utilization to specific products, and the various characteristics of those products.	12/15/2010
Q54	**Is it possible the Product file will be expanded at some point in the future in order to capture other types of benefits (e.g., copay levels, deductibles by service type, OOP max, coinsurance, etc...)?**	12/15/2010
A54	Yes, it is possible the Division will expand the product file, or alternatively ask for a supplemental product data feed to further support Product file analysis.	12/15/2010

Provider File

Q14	**Can the Division clarify the business rules and data submission guidelines on the Provider File for non-Massachusetts servicing providers?**	10/15/2010
A14	It is not a requirement to submit detailed provider information on servicing providers who are out of state, if that information is not readily available in a carriers system. If a member receives services outside of Massachusetts a carrier can opt to submit all relevant provider information on the claim and provider file, just as they would if the provider was in Massachusetts, if this information is available in their system. If it is not available the carrier can indicate this with default values as specified in the ProviderFile Examples.xls document for fields MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location). In this scenario the carrier should not put a corresponding record in the Provider File. This code indicates that the carrier information is not available because the carrier is out of state. The Division will validate that the service was delivered out of state based on field MC015 (Member State or Province). (See Reference File - ProviderFile Examples.xls)	10/15/2010
Q15	**Are carriers required to submit provider information for pharmacies in the Provider File?**	10/15/2010
A15	If the pharmacy is delivering a medical service such as a flu shot, minute clinic services, or other, the pharmacy would be noted as the servicing provider in the Medical Claims File (MC924) and needs to be in the Provider File. If the pharmacy is only dispensing the prescriptions they should not be in the provider file. Pharmacy information is required in the Pharmacy File, specifically fields PC018 through PC024a.	10/15/2010
Q16	**Should the Provider File include records for those providers who do not have claims?**	10/15/2010
A16	Yes, the Provider File should include all Massachusetts providers a carrier is contract with and/or has a record of claims.	10/15/2010
Q17	**Do carriers need to submit Provider File records for non-Massachusetts providers?**	10/15/2010
A17	See FAQ question #14	10/15/2010
Q18	**Do carriers need to submit data for Massachusetts contracted/par/in network providers who are not found as a servicing provider on the claims file?**	10/15/2010
A18	Yes, this is a requirement.	10/15/2010
Q19	**Do carriers need to submit data for Massachusetts non-contracted/non-par/out of network providers who are not found as a servicing provider on the claims file?**	10/15/2010

A19	No, this information is not required to be submitted; however, if this data is already in a carrier's provider database the Division will accept this data.	10/15/2010
Q20	**Do medical carriers need to submit provider records for behavioral health, vision or dental providers, if they contract with a separate carrier for these services?**	10/15/2010
A20	If the medical carrier has these providers in their system they should be submitted. The Division understands that the provider information from the contracted delegated vendors (dental, vision and behavioral health carriers) may differ from the information the medical carrier has.	10/15/2010
Q40	**Please explain the definition of, and the goal of capturing PV058, 'Delegated Provider Flag'?**	12/15/2010
A40	This field indicates whether the provider record was sourced from the carrier's provider data system or from a delegated vendor, such as a behavioral health or dental carve out vendor that the carrier contracts with. This field would help the Division understand if there might be a reason for differences in the consistency, completeness and quality of data in the provider file. Carriers have told the Division that the delegated vendors' provider data may not be as complete and may be structured differently than their own internally contracted provider's data. A value of '1' tells the Division that the data came from an external vendor. In this case, the Division understands that the data was not sourced from its own internal systems, and the Division will relax the thresholds and edits for those provider records. Note: In the carrier submission guide there was a typo. The submission guide definition for this field will also be updated to be consistent with the above definition.	12/15/2010

GIC Linking

Q51	**We participate in the six-plan data aggregation that supports the GIC's health insurance benefits, and as part of that effort have received a "link ID" that permits the GIC's vendor to connect provider information across all six plans. Should we include the link ID in the initial APCD provider file in order to facilitate that process here?**	12/15/2010
A51	GIC carriers should submit the 'link ID' in field (PV041) which was a filler field prior to Version 2.1 of the Provider Submission Guide. The Division will utilize this field value for GIC data submitters based on direction from GIC, VIPs and Mercer.	12/15/2010

Testing

Q1	**When are test submission data due?**	10/15/2010
A1	Carriers should send test data as soon as possible. Test files for all six file types should be submitted and passed for structure no later than February 28, 2011.	04/01/2011
Q2	**How many months of data must be submitted for testing?**	10/15/2010
A2	Carriers must submit at least 1 month of test data for each file type.	10/15/2010
Q3	**Can a carrier submit test data more than once?**	10/15/2010
A3	Yes, carriers may submit test data more than once, or until files have passed the intake data formats, thresholds and validation edits.	10/15/2010
Q59	**Do carriers need to submit each and every file type for initial testing at the same time, or can carriers submit each file type for testing as they are ready?**	12/15/2010
A59	Carriers can submit one test file type at a time if this is preferable.	12/15/2010

Variances

Q22	**When must carriers submit their variance requests to the Division?**	10/15/2010
A22	Carriers were asked to have submitted their variance requests to the Division no later than October 1, 2010. The Division will still consider variance requests submitted after October 1, 2010.	10/15/2010
Q23	**How long will the process take to review carrier variance requests?**	10/15/2010
A23	The variance review process will be conducted from January 2011 through May 2011. During this time, the Division will work closely with carriers to thoroughly review the variance application. The Division will also provide feedback or request additional information to discuss options for reaching an agreeable outcome that is in the public interest. The Division encourages open communication and collaboration between the Division's liaison and carrier representatives during all phases of the variance review process.	04/01/2011
Q24	**What information is required for my request to be considered a 'complete variance request'?**	10/15/2010
A24	A complete variance request must have valid data in Columns E, F, G, and I for each field a carrier is requesting a variance for. Column E (Proposed Threshold) should have a proposed value that the carrier can commit to achieving. If the carrier does not currently collect the data element, a value of 0% is acceptable in this field, but must be explained in some detail in Column I, (Rationale). Column F (Claims Start Date) and Column G (Claims End Date) indicate the time period for the variance. Variance Requests are only considered for a 12 month period on a go forward basis. Carriers may request a historical variance (2008-2010) if necessary, and can extend the variance request for a field through December 2011. The Division requires a detailed remediation plan to support the rationale and requested variance. Each variance request should be submitted along with a signed Certification Form.	10/15/2010
Q25	**Can a carrier submit more than one round of variance requests?**	10/15/2010
A25	A carrier may submit additional variance requests for fields which they have not yet requested a variance. A carrier may update a proposed threshold, rationale, dates, or remediation plan for a field they have already submitted a variance request for, when additional information is available.	10/15/2010
Q26	**Does a carrier need to submit a variance request for a field if the field is not applicable to their lines of business?**	10/15/2010
A26	Yes, the Rationale column should indicate why the field is not applicable to their lines of business.	10/15/2010
Q27	**How long is my variance request valid for?**	10/15/2010
A27	A carrier may submit a variance request for up to one year on a go forward basis.	10/15/2010
Q28	**What happens when the 12-month variance request period expires?**	10/15/2010

A28	Once the variance request has expired, the carrier is expected to have achieved the standard threshold, or an intermediary threshold approved with the attached remediation plan. In cases where a carrier achieves a higher threshold after the 12 months, but still below the standard threshold, the Division may continue to allow a variance if the achieved variance is in line with the initial remediation plan and is improving. A continued variance for a field would require a new variance request, which may be approved for up to an additional 12 months.	10/15/2010
Q29	**Who at the Division should a carrier contact with questions about their variance requests?**	10/15/2010
A29	The Division will be contacting each carrier and sharing with each carrier their point of contact at the Division. This information was distributed to carriers the week of October 18th.	10/15/2010
Q30	**How often can a carrier submit variance requests?**	10/15/2010
A30	Variance requests for a specific field are valid for up to 12 months. A carrier can submit a variance request for a new field, at any time.	10/15/2010
Q68	**What are the Division's goals for the variance application review process?**	2/22/2011
A68	The Division is committed to using the variance application review process to have an open dialogue with payers and to complete a thorough review of the submitted variance applications and all supporting documents. To accomplish this, the Division will meet with payers to provide technical support, to document submission challenges, and to collaboratively discuss remediation plans that will have a mutually beneficial result. The Division hopes the collaborative discussions and active partnership with payers will lead to a final variance application with a signature from a payer representative that reflects a commitment toward a common agreement for the data submitted through 2011.	2/22/2011
Q69	**What is the difference between version 2.0 and 2.1 of the variance application?**	2/22/2011
A69	There were some additional changes to the submission guides from V2.0 to V2.1 (dated December 1, 2010) and the variance request forms were updated to align with the latest version of the submission guides. The changes are reflected in the beginning of the submission guides.	2/22/2011
Q70	**Are payers required to submit data while the variance applications are being reviewed?**	2/22/2011
A70	Payers should utilize the production files submitted by February 28th as well as the monthly submission for March, April, and May 2011 to assist in the completion of the variance application and to facilitate constructive dialogue with the liaisons about proposed thresholds and remediation plans. All production files will be measured against only the final certified and approved variances.	2/22/2011
Q71	**Can payers resubmit an updated variance application request?**	2/22/2011
A71	The Division encourages payers to utilize the results of the edit reports from test and production files to inform the completion of the variance applications. Therefore, the Division anticipates payers will update and resubmit variance request applications several times before the variance application review process is	2/22/2011

complete. Payers may resubmit variance applications before and after February 28th.

Q72	**Are certified signatures required with each updated submission of the variance application?**	2/22/2011
A72	Only the final certified and approved variance application will require a certified signature. The Division will provide payers with greater detail about the process and requirements for submitting the variance application with certified signature soon.	2/22/2011
Q73	**When will payers be notified of the variance approval?**	2/22/2011
A73	The Division believes payers who are actively engaged with submitting production data, updating variance application requests, and maintaining open communication with the Division should have a completed and mutually agreed upon variance application no later than May 31, 2011.	2/22/2011